Inpatient Hospital Services

1. The Department has established a Consultation Program for Elective Surgery. As a condition of reimbursement for all providers of medical and hospital services, Medical Assistance recipients electing to undergo designated surgical procedures must obtain qualified and independent judgments concerning the deferability of the surgery. The designated surgical procedures are:

   - tonsillectomy and/or adenoidectomy
   - hemorrhoidectomy
   - hysterectomy (in absence of diagnosis of cancer)
   - disc surgery (when a discogram, myelogram, or CT scan does not yield an abnormal result)
   - spinal fusion
   - meniscectomy (when an arthroscopy or arthrogram does not document a torn meniscus)
   - submucous resection/rhinoplasty with major septal repair/repair of nasal septum
   - excision of varicose veins
   - coronary artery bypass (in absense of a diagnosis of significant left-main coronary artery occlusion)
   - hernia repair (age 5 or older)

2. Preadmission screening will be required for all acute elective inpatient hospital admissions except admissions for all alcohol and drug abuse, for obstetrics, and for newborns younger than six days old. The provider recommending an acute inpatient hospital admission must contact the Department's preadmission reviewer explaining the reasons for the proposed admission. The reviewer will identify a case for utilization review if the provider and the reviewer cannot agree on the necessity of the admission.

3. Preadmission screening will be required for all inpatient chronic disease and rehabilitative hospital admissions. The screening program is intended to ensure that medical and nursing services are provided in the most appropriate and cost effective setting. The Department will pay for chronic disease and rehabilitation hospital services only when the Department or its agent authorizes these services based on a submission that establishes need prior to admission. Preadmission screening does not apply to inpatient chronic disease and rehabilitative hospital patients who were covered by other insurance (including Medicare) during part of a hospital stay and whose insurance coverage terminated prior to discharge.

4 The Division of Medical Assistance (DMA) intends to establish a new provider type under this Plan called Designated Emergency Mental Health Provider (DEP), also known as an Emergency Service Program (ESP). To qualify as a DEP/ESP, a provider of hospital services must be designated as such by the Commonwealth.

Item 2.a
Outpatient Hospital Services - See Supplement to Attachment 3.1-A, P.1, Item 1, #1 and #4.

Item 4.a.
If a utilization review team recommends that a recipient in a multi-level long-term-care facility be changed to a lower level of care, the facility is responsible for relocating a recipient to the recommended level of care within the facility. The recipient has the right to appeal the recommendation.

3.1-A, Page 2

Item 5

Physician's Services - See Supplement to Attachment 3.1-A, P.1, Item 1, #1.

a. Podiatrists' Services - limited to care which a primary care physician certifies is necessary for the life and safety of the recipient.
b. Optometrists' Services - Available services have been eliminated or limited as follows:

    1. Exclusions consist of absorptive lenses of greater than 25% absorption, prisms obtained by decentration and treatment for congenital dyslexia.
    2. Services that are limited include provision of: tinted lenses, two pairs of eyeglasses instead of bifocals, new lenses, routine eye examinations, and contact lenses.
    3. The volume purchase of eyeglasses limits the selection of frames and lenses to a basic assortment from the optical supplier.

C. Chiropractic Services - not provided
D. Other Practitioners' Services - include registered nurse services as part of a Case Management Screening Project team in conjuction with the Case Management Screening Project cooperatively administered by the Department of Public Welfare and the Department of Elder Affairs for assessment, referral, and follow-up services. Other practitioners' services also include psychologists' services, which are limited to psychological testing only.

Item 7

Home Health Services - Home health aide services require prior authorization for those hours in excess of 120 hours in each of the two preceding months.

Medical supplies, equipment, and appliances must be prescribed or ordered by the recipient's physician and must be furnished and claimed directly appropriate vendors in accordance with the Department's regulations relative to drugs, restorative services, and rehabilitative services. Home health agencies must transmit such prescriptions and orders to vendors who are providers in the Medical Assistance Program

Item 8

Private Duty Nursing Services - are available in the patient's home with prior authorization from Medical Assistance and in accordance with Detsel v. Sullivan 895 F. 2nd 58 (1990).

Item 9

Clinical Services are available with limitations. The Department only pays for freestanding ambulatory surgical services that are medically necessary and appropriately provided in the most cost-effective settings. Freestanding ambulatory surgical center services are limited to surgical, diagnostic, and medical services that provide diagnosis or treatment through operative procedures requiring general, local, or regional anesthesia, and must be furnished to patients who do not require hospitalization or overnight services upon completion of the procedure, but who require constant medical supervision for a limited amount of time following the conclusion of the procedure.

Item 9a

The Division of Medical Assistance (DMA) intends to establish a new provider type under this Plan called Designated Emergency Mental Health Provider (DEP), also known as an Emergency Service Program (ESP). To qualify as a DEP/ESP, a provider of clinical services must be designated as such by the Commonwealth.

Item 10

The following dental services are not covered: an examination; a standard consultation visit; a hospital comprehensive consultation visit; panoramic X-rays for nonsurgical conditions; the restoration of a fractured permanent anterior tooth with composite material and bonding or its equivalent; acrylic-jacket crowns and porcelain-jacket crowns; a cast core; fixed bridgework; repairs to existing bridgework; Maryland bridges; and apicoectomy with retrograde filling as a separate procedure; and partial upper and lower dentures with bar; relines to partial and upper an d lower dentures; orthodontic diagnosis; interceptive orthodontic-treatment visits; limited orthodontic treatment; full orthodontic treatment; replacement retainers.

The following restrictions apply to dental services:

a) Payment for deep scaling and curettage is limited to once per quadrant per three year period.
b) Payment for crowns is limited to anterior teeth, one per recipient per 12-month period, and no sooner than 12 months from the date of the last crown.
c) Payment for root-canal therapy is limited to single- and double-rooted teeth.
d) The fee for dentures includes payment for any relines necessary within 12 months of the dispensing date.
e) Subsequent relines are reimbursable without prior authorization once every three years.
f) Implants are not reimbursable.
g) Treatment for temporomandibular joint disease is not reimbursable.
h) Unless specifically requested by the Department, models will no longer be accepted in place of photographs and slides for prior authorization requests for orthodontic treatment

(h) Unless specifically requested by the Division, models will no longer be accepted in place of photographs and slides for prior authorization requests for orthodontic treatment.

(i) The recipient's guardian or the facility's director of nursing must sign the documentation that accompany prior authorization requests for dentures for recipients in long term care facilities.

(j) When reviewing prior authorization requests for the replacement of dentures, the Division will take into consideration the circumstance necessitating the request.

(k) Payment for inpatient exodontia services is limited to instances where the recipient's life would be threatened if the exodontia services were performed in the office.

Item 11

Therapies and Related Services - Speech, occupational and physical therapies must be goal-oriented. Diversional, recreational, and maintenance therapy are not reimbursable services. Audiology Service Limitations - The Division will not pay for replacing or dispensing any hearing aid without medical justification if any such hearing aid was dispensed within the preceding 24 months. The Division will pay for a replacement hearing aid and the dispensing fee for such replacement only if an audiological evaluation indicates that changes in the recipient's condition have rendered the current hearing aid inadequate and that a new hearing aid will improve the recipients's hearing. The results of any such audiological evaluation must be fully documented in the recipient's health-care record.

Item 12

a. Prescribed Drugs - Legend FDA-approved drugs are reimbursable subject to the conditions specified in 106 CMR 406.000. Non-legend over-the counter drugs are not reimbursable unless a primary care physician certifies that the drug is necessary for the life and safety of the recipient, and, if applicable, prior authorization has been obtained. Insulins are reimbursable for recipients without restrictions.

b. Dentures - See Supplement to Attachment 3.1-B, page 3, Item 10 above.

c. Prosthetic Devices - no changes in Department policy.

d. Eyeglasses - See Supplement to Attachment 3.1-B, Page 2, Item 6-b.

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State: Massachusetts (DPW)

Supplement to Attachment 3.1 B
Page 3b

Item 13

(d) Rehabilitative Services

Municipally Based Health Care Services (MBHCS)

Services Included

MBHCS are services which otherwise are reimbursable hereunder and are provided by or through the Massachusetts Department of Education (DOE) or a Local Education Authority (LEA) to students with special needs pursuant to an Individual Education Plan (IEP). Specifically, those services include:

- o Early and periodic screening and diagnosis and treatment (EPSDT) and family planning services and supplies.
- o Physician's services.
- o Medical and other remedial care provided by licensed practitioners.
- o Clinic Services.
- o Dental Services.
- o Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders.
- o Prescribed drugs, dentures, prosthetic devices and eyeglasses.
- o Diagnostic screening, preventive, and rehabilitative services.
- o Transportation for the recipient by ambulance, taxicab, common carrier or other appropriate means.

MBHCS does not include: Educational services, vocational and training services, Research and experimental services, Room and Board.

Item 16

Preadmission screening will be required for all non-court-ordered admissions of Medicaid recipients (as per 42 CFR 441.152). Such certification of the need for services for conversion cases (people applying for Medicaid eligibility while hospitalized in an inpatient psychiatric facility) will be made by the team responsible for the plan of care (42 CFR 441.153(b)). Periodic reviews of use will be performed by the Medicaid agency or its designee.

Item 20

The major categories of services available to pregnant women as pregnancy-related services include inpatient hospital, outpatient hospital, laboratory and X-ray, family planning, physician, clinic, dental, prescription drug, and nurse-midwife services.

Extended services to pregnant women may be provided by physicians and community health centers. Such extended services include coordinated medical management, health-care counseling, obstetrical-risk assessment and monitoring and rehabilitation services including treatment for alcoholism and drug dependency.

Item 23.d.

Skilled nursing facility services for patients under 21 years of age are covered if a Department of Public Health review team approves the facility.

Item 23.f.

The Department will pay for personal care services provided to Medical Assistance recipients who can be appropriately cared for in the home and where the following conditions are met.

A. The personal care services must be prescribed by a physician.

B. The recipient's condition must be permanent or chronic in nature.

C. The recipient, as determined by the personal care agency, must require physical assistance in either of the following:

1. Activities of daily living for a minimum of ten hours per week.
Activities of daily living include the following:

a. mobility - physically assisting a consumer who has a mobility impairment that prevents unassisted transferring, walking, or use of prescribed durable medical equipment;

b. assistance with medication or other health-related needs - physically assisting a consumer to take medications prescribed by a physician that otherwise would be self-administered;

c. bathing or grooming - physically assisting a consumer with basic care such as bathing, personal hygiene, and grooming skills;

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d. dressing - physically assisting a consumer to dress;

e. range-of-motion exercises - physically assisting a consumer to perform range-of-motion exercises;

f. eating, meal preparation, and clean-up - physically assisting a consumer to eat (this can include assistance withtube-feeding and special nutritional and dietary needs); and

g. toileting - physically assisting a consumer with bowel and bladder needs.

2. A combination of activities of daily living and instrumental activities of daily living for a minimum of 14 hours per week. Instrumental activities of daily living include the following:

   a. household services - assisting with monitoring and supervising household management tasks, including laundry, shopping, and housekeeping, that are incidental to the care of the consumer;

   b. transportation - accompanying the consumer to medical providers; and

   c. special needs - assisting the consumer with the care and maintenance of wheelchairs and adaptive devices, personal care services paperwork, and other special needs approved by the Department as being incidental to the care of the consumer.

State/Territory: Massachusetts (DMA)

A. Target Group:

See pages 1a through 1q

B. Areas of State in which services will be provided:

[*X*] Entire State.

[] Only in the following geographic areas (authority of section 1919(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of services

[] Services are provided in accordance with section 1902 (a)(10)(B) of the Act.

[*X*] Services are not comparable in the amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of services:

See pages 1a through 1q

E. Qualifications of providers:

See pages 1a through 1q

A. Target Group:

1. For the Preferred Physician Program: all medically needy and categorically needy individuals except those who are 65 years of age or older.

2. For the Prepaid Medical Care Program: all medically needy and categorically needy individuals.

3. For High-Cost Case Management: all medically needy and categorically needy individuals who meet the following two criteria.

   a. The recipient is receiving treatment for an illness or condition determined by the Department to be catastrophic and likely to result in hospital expenses in excess of $20,000 or a length of stay in excess of 15 days.

   b. The recipient has the potential to benefit from alternative treatment and care that can be delivered in a cost-effective manner.

D. Definition of Services:

1. Arrange for the delivery to recipients of all ambulatory and inpatient medical services, provided by other medical providers or facilities, when necessary.

2. Maintain an integrated medical record for each recipient that is consistent with current professional standards and documents all care provided.

3. Document all referrals made to other providers on behalf of enrollees.

4. Provide patient education to enrollees about access to necessary medical services, with emphasis on noninstitutional and community settings.

5. High-Cost Case Management will provide an assessment and, where applicable, an alternative treatment plan and monitoring of care.

E. Qualification of Providers:

1. For High-Cost Case Management, a provider must be either a registered nurse licensed in Massachusetts, a hospital discharge planner, or a physician licensed in the Commonwealth of Massachusetts.

2. Otherwise, a provider must participate in the Medicaid Program and be organized to provide the following array of primary-care services:

a. preventive services and ongoing medical care management;

b. 24-hour, seven-days-a-week telephone availability either directly or through a coverage arrangement;

c. a referral network that includes all the standard medical and surgical subspecialties; and

d. full admitting privileges at one or more hospitals for necessary inpatient clinical management

3. For the Preferred Physician Program, a provider must also

a. be a family practitioner, pediatrician, or general internist;

b. provide primary care in solo or group practice; and

c. practice in accordance with the contractual requirements of the Preferred Physician Program.

4. For the Prepaid Medical Care Program, a provider must be a state licensed and/or certified community health center, hospital outpatient department with an organized primary care program, or individual physician who practices in a medical group (either multispecialty or family practice) furnishing adult and pediatric medicine to enrollees on their premises.